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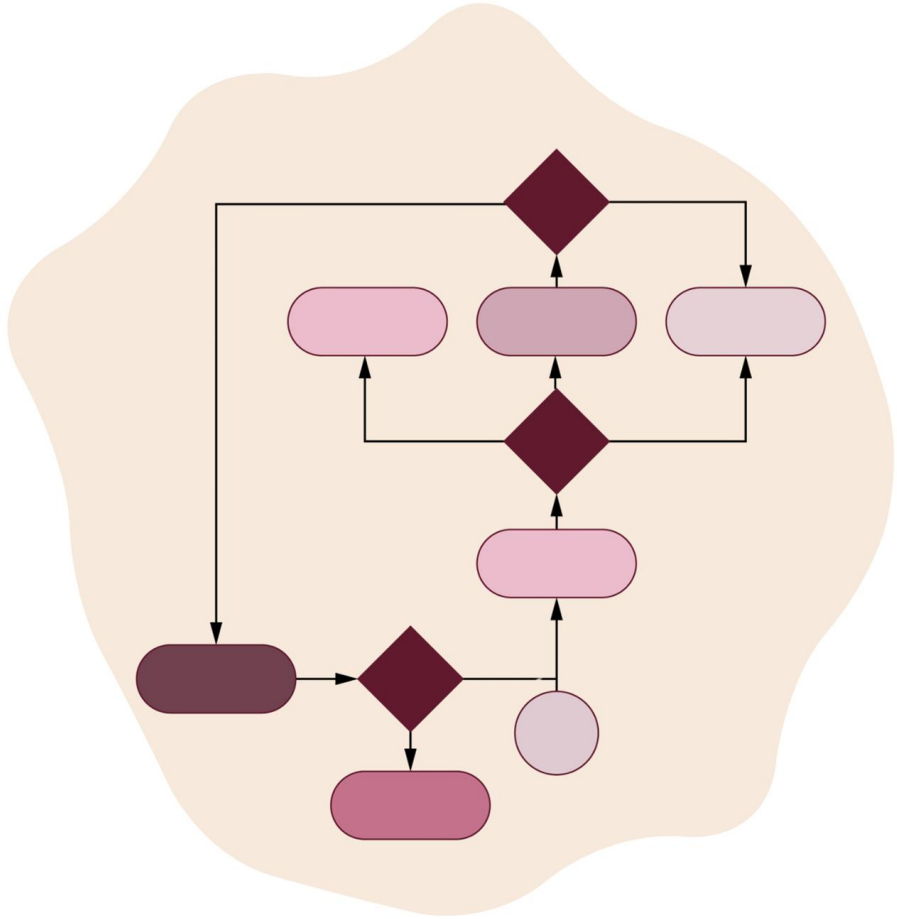
# Creating Guidelines & Evidence-Based Pathways

Laurence Zulianello[1]

[1] *JEADV Editorial Office*



# Recommendation Strength

- A common language - Strong, weak, no recommendation
- Based on evidence and consensus

| Strength of recommendation | Wording | Symbols | Implications |
|---|---|---|---|
| **Strong recommendation for** the use of an intervention | '**We recommend** . . .' | ↑↑ | We believe that all or almost all informed people would make that choice. Clinicians will have to spend less time on the process of decision-making and may devote that time to overcome barriers to implementation and adherence. In most clinical situations, the recommendation may be adopted as a policy. |
| **Weak recommendation for** the use of an intervention | '**We suggest** . . .' | ↑ | We believe that most informed people would make that choice, but a substantial number would not. Clinicians and health care providers will need to devote more time on the process of shared decision-making. Policy makers will have to involve many stakeholders and policy making requires substantial debate. |
| **No recommendation** with respect to an intervention | '**We cannot make a recommendation** with respect to . . .' | 0 | At the moment, a recommendation in favour or against an intervention cannot be made due to certain reasons (e.g. no reliable evidence data available, conflicting outcomes, etc.) |
| **Weak recommendation against** the use of an intervention | '**We suggest against** . . .' | ↓ | We believe that most informed people would make a choice against that intervention, but a substantial number would not. |
| **Strong recommendation against** the use of an intervention | '**We recommend against** . . .' | ↓↓ | We believe that all or almost all informed people would make a choice against that intervention. This recommendation can be adopted as a policy in most clinical situations. |

→ Graded according to **evidence quality** and **clinical agreement**
They guide how strongly a treatment should be applied **in practice**
This helps **standardize decisions across clinicians**

# High Visibility

- ❑ Key messages at a glance
- ❑ Designed for fast decision-making

| Statement + strength | | Level of consensus |
|---|---|---|
| We **recommend** to start with higher ciclosporin dosages in order to achieve a more rapid response in AE patients who are candidates for systemic treatment. | ↑↑ | >75%<br>  <br>(14/15)<br>Expert consensus |

| C. Recommendations for patients with psoriasis during breastfeeding | |
|---|---|
| **We recommend** using NB-UVB, ciclosporin, certolizumab pegol, etanercept, infliximab, adalimumab, ustekinumab during breastfeeding. | ↑↑ |
| **We cannot make recommendations** about the use of guselkumab, tildrakizumab, risankizumab, secukinumab, ixekizumab, brodalumab, bimekizumab owing to insufficient clinical data | 0 |
| **We suggest against** using methotrexate* during breastfeeding. | ↓ |
| **We recommend against** using acitretin, apremilast and deucravacitinib during breastfeeding. | ↓↓ |

**Possible to use methotrexate only if breastfeeding can be delayed for 24 hours after methotrexate administration, but this is difficult to achieve in practice. NB-UVB, narrowband UVB.*

- Dapsone may also be recommended as first line in combination with topical corticosteroids (class II-III) or tacrolimus (**strong consensus: 97%**).
- Systemic antibiotics including macrolides, and tetracyclines (in children above the age 10 years) may be considered in case of contraindications to or adverse effects of dapsone (**consensus: 84%**).

→ This supports **quick, safe clinical choices**

# Severity-Driven Strategy

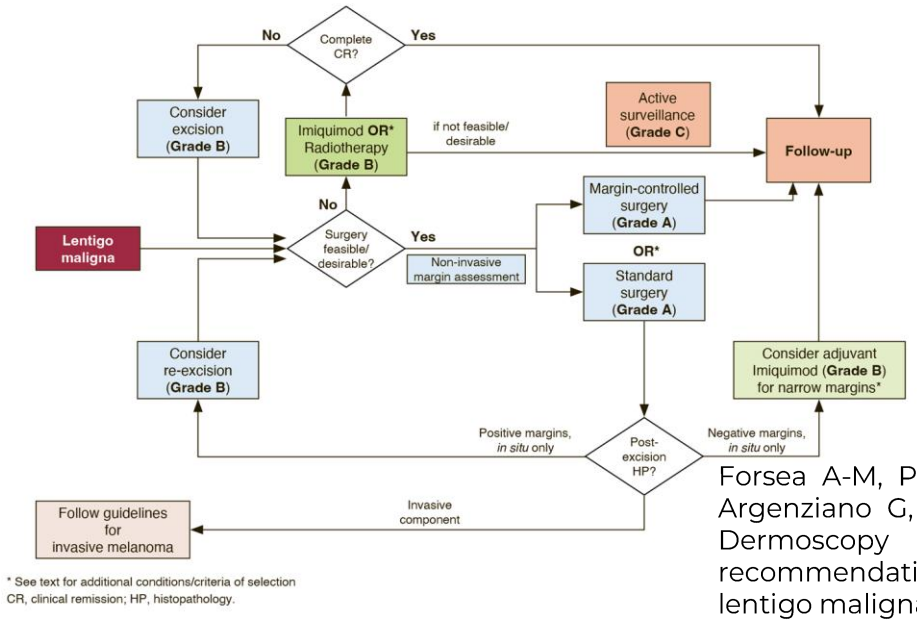
- Mild, moderate, severe disease
- Stepwise treatment decision

| Mild | Moderate | Severe |
|---|---|---|
| **1st Line:** potent tCS and/or potent iS<br>**2nd Line**: tJAKIs or tCI<br>**3rd Line:** topical dapsone<br><br>***Note:***<br>• Combination of the treatments possible<br>• In case of disease progression follow the suggestions for "moderate disease" | **1st Line:** HCQ<br>**2nd Line** systemic retinoids or doxycycline<br><br>***Note:***<br>• Consider adjuvant topical treatment (follow the suggestions for "mild disease")<br>• Combination of the treatments possible<br>• In case of disease progression follow the suggestions for "severe disease" | **1st Line:** sCS and/or MMF or MTX<br>**2nd Line**: biologics & small molecules or Cys<br>**3rd Line:** pioglitazone<br><br>***Note:***<br>• Consider adjuvant topical treatment (follow the suggestions for "mild disease")<br>• Combination of the treatments possible<br>• Short-term sCS may be ideally used as a temporary measure, as a bridge to the longer-acting medication |

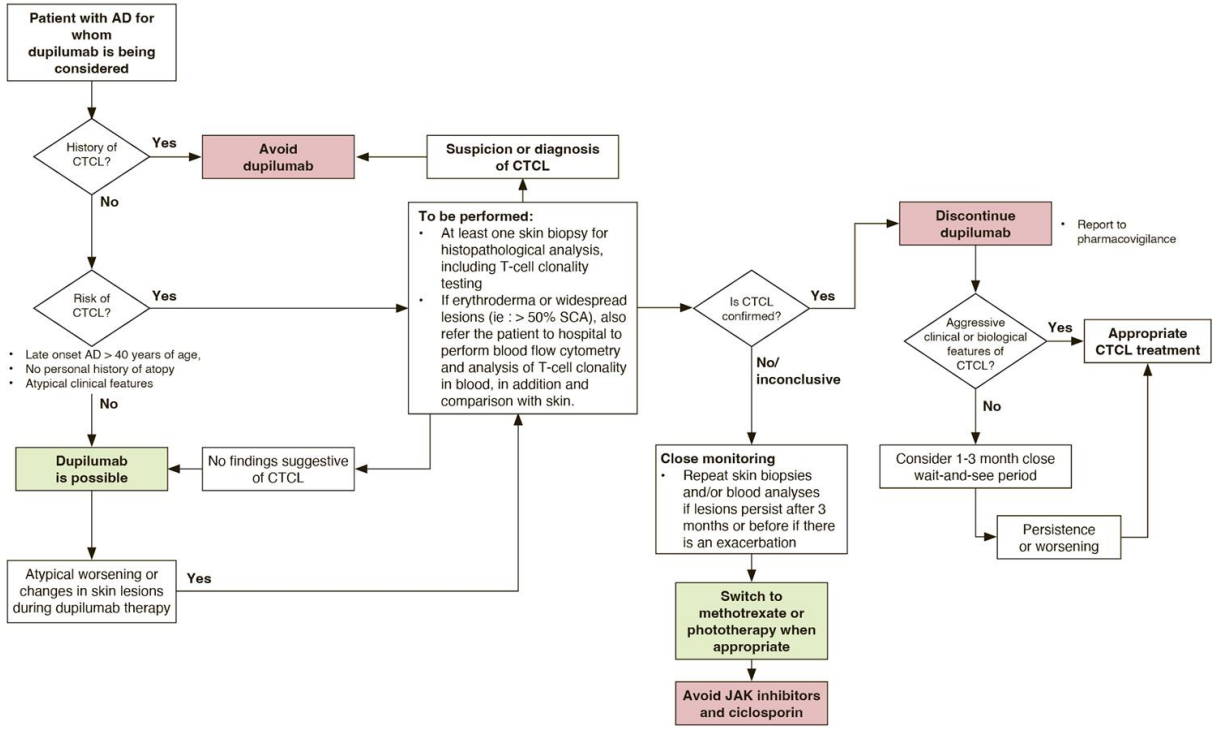
→ Therapeutic choices are guided by **disease severity and clinical response**.
Treatment is adjusted or escalated as needed.
This ensures **consistent and proportionate care.**

# Visuals clarify complexity

- Algorithms & flowcharts
- Stepwise treatment escalation

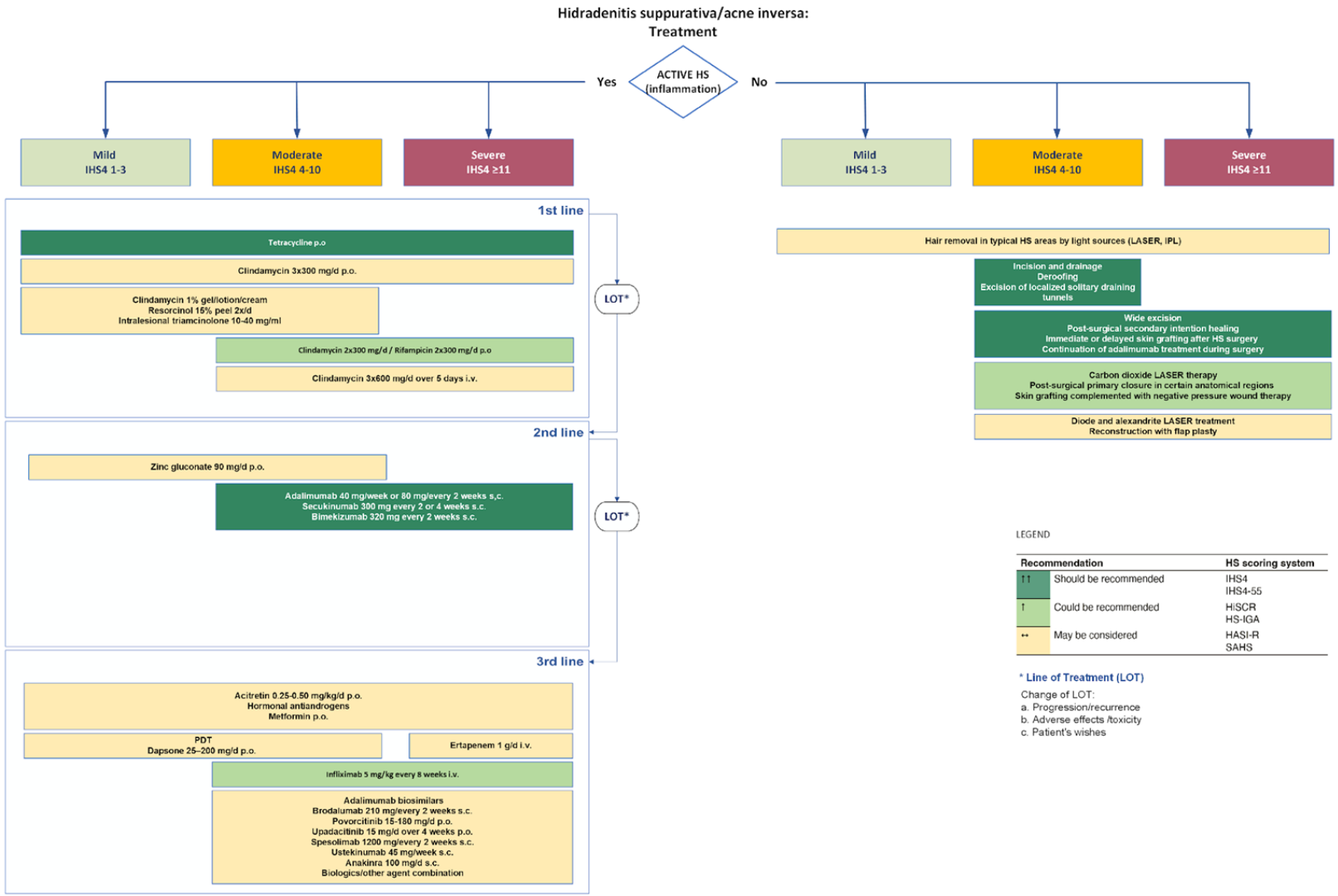


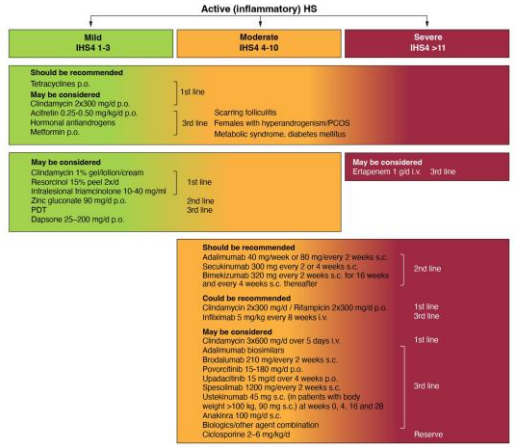

Forsea A-M, Pampena R, Akay BN, Apalla Z, Argenziano G, Briatico G, et al. International Dermoscopy Society consensus recommendations for the management of lentigo maligna. J Eur Acad Dermatol Venereol. 2026. https://doi.org/10.1111/jdv.70406

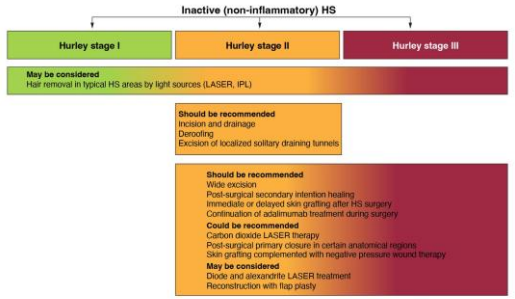



Nast A, Al Wattar BH, Beylot Barry M, Brüggemann H, Bukvić Mokos Z, Caruana DM, et al. Update of the EuroGuiDerm evidence-based guideline for the treatment of acne—Short version. J Eur Acad Dermatol Venereol. 2026. https://doi.org/10.1111/jdv.70331

Algorithms and flowcharts translate guidance into **clear visual pathways**.
They keep **recommendations accessible** and **clinically relevant**.
This helps **standardize care** at the point of use.




Zouboulis CC, Bechara FG, Benhadou F, Bettoli V, Bukvić Mokos Z, Del Marmol V, et al. European S2k guidelines for hidradenitis suppurativa/acne inversa part 2: Treatment. J Eur Acad Dermatol Venereol. 2025;39:899–941. https://doi.org/10.1111/jdv.20472

EA DV TOGETHER FOR BETTER